Client Intake Interview

The following questionnaire is to be completed by the client's parent or legal guardian (with input from the client as appropriate). This form has been designed to provide essential information before your initial appointment in order to make the most productive and efficient use of our time. Please feel free to add any additional information that you think may be helpful in understanding the client.

All information provided by you is strictly confidential and will only be released in accordance with HIPAA guideline.

General Contact Information

Date of Intake: _____

Name of person providing information:		Relationship to client:	
Legal name of client:		Client date of birth:	
Male / Female		Age:	
Home Address:			
Home Phone:		Cell phone:	
Work Phone:		Other Phone:	
Email Address:			
Preferred method of contact:	Phone	Text	Email
Best time to contact:			
Referral Source:			

Emergency Contact Information

Name:	
Relationship to the client:	
Contact information:	

Home Information

Parent/Guardian Marital status:	Married	Remarried	Divorced	Separate	Widowed	Single	Co-habitants	Other

Parent/Guardian Name:		Parent/Guardian Occupation:	
Parent/Guardian Name:		Parent/Guardian Occupation:	

People Living in the Home:

Name	Relationship	Age	Significant Health or Behavioral concern:

Languages spoken in the house:	
Relevant Legal issue (Client/Family):	

***If divorced a copy of the custody agreement indicating which parent(s) have the right to obtain medical treatment will be needed before the assessment or treatment is started.**

Behavioral/Psychological History

Please list any doctors or professionals who have evaluated or diagnosed the client:

Profession & Affiliation	Date of Evaluation / Report	Diagnosis

Suicidal Behaviors – Date of document, method and lethality:	
Abuse History – Experienced or Perpetrator:	
Sexual History -	
Substance Abuse – Past or present use of alcohol, drugs, prescription, nicotine:	

*Please provide a copy of any reports that are available and that may be useful in developing a comprehensive treatment plan.

Pre-natal & Delivery History

Pre- natal complications:		Delivery complications:	
If yes, please describe:			

Developmental History

Please indicate the client's age for each milestone, if you cannot remember the client's approximate age just indicate "normal", "late/early", or put a "?". Leave the box blank if the client has not yet reached the milestone.

Rolled over:		**Sat:**		**Stood:**	
Crawled:		**Walked:**		**1st Word:**	
1st Phrase:		**1st Sentence:**		**Toilet Trained (Day):**	
Toilet Trained (Night):		**Self-dressed:**			
Other:					

Medical History

Primary Care Physician:			
Address:			
Contact Number:		Fax:	

Please list current medical diagnoses:

Date	Physician / Organization	Diagnosis

Please list any previous medical diagnoses from the last 5 years:

Please list any current medications, the prescribing doctor, and what the medication has been prescribed to treat, how long the client has been taking it:

Start Date	Medication	Prescribing Physician	Reason

Previous Medications: Please list any previously prescribed medications, the prescribing doctor, what the medication was prescribed to treat, why it was discontinued, and the length of time that the client took the medication:

Doctor	Medication	Reason	Reason Discontinued	Duration

Vitamins and Supplements:

Vitamin / Supplements	Duration of time taken	Reason

Allergies:

Please mention all types of allergies including food, seasonal and environmental and any medication or treatment being done for allergy treatment:

Family History

Please list significant Family Medical, Behavioral/Psychological, Substance Abuse, etc.

History including doctors or professionals who have evaluated or diagnosed the family member:

Relationship to Client	History of Diagnosis

Do you have any pets? **Yes** **No**

If yes, please mention:

Permission to contact Primary Care Physician (PCP)? **Yes** **No**

If yes, please complete Release of information form.

Name of any other Behavioral Health Clinician:

_____

Permission to contact Behavioral Health Clinician? **Yes** **No**

If yes, please complete Release of info form.

Phone: 773-553-0900 - Fax: 833-409-2227 - www.Happyian.com -
happyian@happyianaba.com

Please sign here to authenticate the above documents are filled with the parent/legal guardian's consent _____

Date:

Educational School Information

School Name:		District:	
Grade:		Class Type:	
Name of Teacher(s):			
Does the Client have a current IEP:		Does the Client have any behavioral intervention plan:	

Additional School Services:

Service	Minutes / week	Service goal:
Other:		

Private Therapies

Current Therapies:

Type of Therapy	Therapy Provider	Duration / week	Duration with provider:	Comments
Other:				

Past Therapies:

Type of Therapy	Therapy Provider	Duration / week	Duration with provider:	Comments
Other:				

Additional Client Information:

Does your child have any issues with sleeping or eating? Yes No

If so, please describe:

Does your child have any infectious diseases? Yes No

If yes, please list:

Any Additional Significant information:

Communication

Please provide information on the client's method of communication:

Reinforcer Assessment

Preferred Item's/Activities:

Please provide information on the things or activities that your child enjoys. For example, certain toys, food, games, places, people, etc.

Client Daily Living Skills

(Sleeping, Eating, Grooming, Dressing)

Sleeping: Eating: Brushing teeth: Nail trimming: Hair cut: Dressing: Tying shoe laces: Button snapping: Zipping clothes: Additional Information:

Client Daily Living Skills Continued….

Family Goals

Please describe your child's assets or strengths:

Please describe any concerns you have related to your child's development:

Please describe any problem behaviors that you are concerned about:

Please list 3-5 things you would like the client to be able to do more often or that you would like the client to be able to do more easily:

Please list 3-5 things you would like the client to do less often:

Additional Information:

Client Availability Information

Days and time available:

Are there any days and times that you are not available for ABA sessions?

If so, please mention:

Client Environmental/Cultural Preference

Do you prefer therapists take off their shoes? Yes No

Do you prefer therapists park on the street, driveway, or elsewhere? Yes No

If yes, please mention the location:

Are there any spiritual or cultural variables that we should aware of that may impact services?

Yes No

If yes, please describe:

Client Insurance Information

Name of the Insurance Company:

Subscriber's Name:

Subscriber's Date of birth:

Identification Number:

Group I.D:

Secondary Insurance Information (If Applicable):

Expected start date for treatment:

Expected date for in person clinician/BCBA Assessment:

Any Special request/limitations for treatment or team:

Check off that the following items were explained:

Assessment Process	
BCBA makes clinical recommendations based on the assessment**.**	
Minimum number of treatment hours required is minimum 15 hrs. based on 15-20 hrs. recommendation and minimum 20 hrs. based on 25-30 hrs. recommendation by the BCBA.	
Family Treatment Guidance is required and obligatory.	
Child is typically selected off wait list based off availability. If availability changes prior to or during assessment phase, this can affect our ability to move forward with services (may go back on wait list).	

This intake interview was completed by:

	Date:	

Happyian, LLC

Address: 10512 ridge cove drive, Chicago Ridge, IL 60415

Tel:1-773-553-0900

Fax:1-833-409-2227

www.Happyian.com

Insurance Benefits Verification Form

Date of the Intake:

Client Service Co-Ordinator (CSC) Name:

Client Information:

Caller's Name:

Relationship to the client:

Client's Name:

Gender:

Date of Birth:

Address:

Contact Number:

Email address:

Referral Source:

Diagnosis Information:

Is the client diagnosed:

Diagnosis:

Date of the diagnosis:

Diagnosing Physician/Organization:

Contact information of the physician:

Insurance Information:

Primary Insurance:

Subscriber's Name:

Subscriber's Date of Birth:

Name of the Insurance:

ID Number:

Group Number:

Contact Information:

Secondary Insurance: If Applicable,

Subscriber's Name:

Subscriber's Date of Birth:

Name of the Insurance:

ID Number:

Group Number:

Contact Information:

Insurance Benefits Verification Information:

Contact the insurance and confirm the benefits for the treatment.

Date:

Billing Specialist Name:

Name of the Insurance company:

Mode of contact:

Contact Information:

Insurance Representative Name:

Call Reference #

Type of Insurance:

Annual Deductible amount:

Is deductible amount met:

Annual Co-insurance:

Is co-insurance active:

Co-pay:

Annual Out of Pocket (OOP) amount:

Is OOP met:

Does the insurance require a pre-authorization/referral for treatment:

Additional Notes:

INFORMED CLIENT SERVICES CONSENT FORM

This consent form contains important information about Happyian, LLC, business policies and professional services offered to our clients, families, and caregivers. This form also outlines the rights and responsibilities of the client and Happyian, LLC.

SERVICES OFFERED

I have been informed that all assessments and treatments are based on the principles of Applied Behavior Analysis (ABA) and Behavior Modification Techniques. Furthermore, I understand that all services are directed by a Board-Certified Behavior Analyst (BCBA) who is nationally accredited. The BCBA supervises the Behavior Technicians who will also work with the client, family, and caregivers. I have been informed of the specific treatment plan as pertains to my child. I understand that treatment is based on principles of Applied Behavior Analysis and Behavior Modification Techniques. I understand that there are risks involved with noncompliance to treatment recommendations such as lack of progress and increase in maladaptive behaviors.

ASSESSMENTS/PREPARATION

I understand that a variety of assessment tools may be used for assessment procedures, and the development of programs and goals. Assessment tools are determined based on the skill set of the client. I understand that on occasion, there may be a need for the BCBA or a representative of Happyian, LLC to consult with outside therapists, doctors, schools or other entities that may provide pertinent information toward a successful and complete treatment plan for my child. Happyian, LLC takes great pride in providing quality services. I understand that in some instances I will need to provide an area for table/sit down work. I also understand that therapists will make every effort to clean used areas back to the condition it was found.

PAYMENT AUTHORIZATION

I authorize Happyian, LLC, Inc. to use the insurance card provided by the insurer to make appropriate billing to my insurance company for ABA services rendered.

CLIENT, PARENTAL AND PROVIDER RESPONSIBILITY TO APPOINTMENTS

I understand that Happyian, LLC, Inc., has a cancellation policy for their clients and staff. This policy was gone over with me in the Policies and Procedures for Parents and Guardians. I agree to the cancellation policy as written including: notifications to appropriate Happyian, LLC staff methods of communicating cancellations, sickness, and excessive cancellations. I have been given an opportunity to review the Policies and Procedures for Parents/Guardians for Happyian, LLC, Inc. which includes patient rights, responsibilities, and ethics and they have been explained to me. I understand that I will be required to give consent for release of information to Happyian, LLC in the event that I decide to transfer to another clinician or program prior to discharge.

RESOURCES AND CARE OPTIONS

I have been given a resource guide that includes resource and care options such as respite options.

CONSENT FORM

I have been given the opportunity to review the Consent Form for Happyian, LLC and they have been explained to me.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Printed Name: _____

Happyian, LLC Staff Signature: _____ **Date:** _____

Happyian, LLC Staff Printed Name: _____

Title: _____

POLICIES AND PROCEDURES FOR PARENTS/GUARDIANS

(Updated 2-2023)

Session Procedures:

1. A guardian or caretaker, who is over 18, must be present in the home or location of service to the client at all times. A parent or adult needs to sign the session note at the end of each session.
2. Any supplies provided by ABA team must be reserved for sessions. Please refrain from using supplies without a team member present.
3. Communication with Behavior Techs is limited to temporary schedule changes; all other issues regarding scheduling or programming should only be addressed directly to BCBA. Please refrain from asking the Behavior Tech to relay information to the BCBA. Any concerns or grievance should be directed to the BCBA via phone call or email. If the grievance is with the BCBA, it should be directed to the designated case Higher Management.
4. For the safety of clients, staff is trained to contact emergency services in the event of an emergency that they deem warranted.
5. In the event that a client is displaced from home to emergency situations, such as natural disasters, services will continue to be provided after an agreed location is settled upon in order to ensure continuity of services.

Cancellation Procedures:

Business Responsibility for Staff Cancellation:

1. Staff will be responsible for notifying clients and company of vacations four weeks prior to the assigned scheduled hours.
2. When emergency cancellations occur from staff, the company will attempt, but cannot guarantee staff coverage.

Over 24 hours' notice:

1. Please notify both BCBA and BT via email when a conflict with scheduling occurs and you are giving more than 24-hour notice.
2. Notify both BCBA and BT via email any planned vacations at least 2 weeks in advance.

3. Schedule changes can be requested, but are not guaranteed, dependent on staff availability, and BCBA approval. Schedule changes will require a two week notice for consideration and/or implementation.

Under 24 hours/sickness notice:

1. Please notify both BCBA and BT via text when a conflict with session occurs and is less than 24 hours, including sickness or other emergency situations. Please ensure at least one team member responds to the alteration. A cancellation fee may be billed per Happyian, LLC if session is cancelled with less than 24-hour notice-unless your child is ill.
2. Note that for any scheduled session, if your child is not present within 15 minutes of scheduled start time, we reserve the right to consider that a less than 24 hour canceled session.
3. Please notify BCBA and BT if the child has a fever, green or colored nasal discharge vs clear, persistent cough, sore throat, and/or vomiting or diarrhea. The child needs to be fever free for 24 hours without the use of fever reducing medicines, before returning to sessions. If your child stayed home from school due to illness, session should be canceled as well. If your child shows these symptoms when the staff arrives for session, they reserve the right to immediately end session and a charge may be applicable for not giving sufficient notice to team of your child's symptoms.
4. Scheduled session times need to be adhered to. Staff is scheduled for their hours for full time status based on their regular scheduled sessions. If on rare occasions, session needs to be shortened (start later or end earlier) this needs to be relayed one hour before start time.
5. Notify staff if anyone in house or session location has any of the above-mentioned symptoms. Staff may cancel at their discretion.

Excessive cancellations:

Note that if more than 10% of scheduled sessions are canceled by client per month, you may be subject to a decrease in session's hours. This applies to frequent shortening of sessions as well.

Holidays:

Note that Happyian, LLC respects family time; therefore, sessions will be cancelled: New Year's Day, Easter, Memorial Day, Independence Day, Labor Day, Thanksgiving, Black Friday, Christmas Eve, Christmas Day.

Administrative Procedures:

1. Communication during the week (text, email, or phone call message) will get a response within 24 hours. Contact staff only during business hours Mon through Fri 8a-6p, unless it concerns the immediate Sat session, and only when necessary or emergent for scheduling changes.
2. Copays and deductible and payments are to be made within 15 days from the date of receipt of invoice sent to you via email.
3. Parents are required to attend one hour of training 80% of the scheduled weeks within the quarter.

Happyian, LLC's responsibility to Client:

1. Provide consistent sessions arriving on time and limiting cancellations.
2. Provide ethical and responsible services to the client at all times.
3. Provide reasonable access to care.
4. Make referrals for any recommended services that they are unable to provide if requested.
5. Inform parents of methods of resolving complaints or issues.
6. Evaluate effectiveness of services with quarterly phone calls with parents by the management, annual anonymous satisfaction surveys, and ongoing evaluation of progress made in skill acquisition and reduction of problem behaviors. Quality improvement plan will be implemented based on anecdotal parent/guardian feedback, survey results, and results of ongoing clinical evaluation of client progress.
7. BCBA will supervise sessions at a minimum of 10% of total session hours.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____

Date: _____

Happyian, LLC Staff Printed Name: _____

Happyian, LLC Staff Signature: _____

Date: _____

Parent/Caregiver Involvement Family Treatment Guidance (FTG) Policies & Procedures

Family Treatment Guidance is a mandatory component of an Applied Behavior Analysis (ABA) individualized treatment plan. Insurance companies require parent and/or caregiver education and participation. The role of the ABA team (BCBA and Behavior Technicians) is to guide, oversee, and design programs, or to implement programs as a part of ABA therapy. The ultimate responsibility for the effectiveness, generalization, and maintenance of skills taught and behaviors reduced using ABA methodologies lies with the parents and/or caregivers. Insurance companies require parent and/or caregiver participation and that all treatment plans include specific goals for the client's family. You will work with the BCBA to create a minimum of 2 specific parent/caregiver goals. Goals are individualized to your child and family and the BCBA will help you determine specific areas to focus on. Family treatment guidance will typically occur 1-2 times a week for 1 hour at a time with the BCBA and is made up of three main components.

A. Parent/Caregiver Education:

a. Discuss ABA principles through curriculum-based lessons and conversations with BCBA:
    1) Learn basic ABA concepts and how to apply them with your child.
    2) Focus on specific areas applicable to your child and family.
b. Training on any skills parent's request guidance with outside of treatment plan goals including:
    1) Potty training
    2) Independence with meals

B. Behavior Management/Skills Training:

a. Parents are supported in developing specific behavior management/skills through: modeling and demonstrations.
b. Practicing in the moment and receiving feedback and assistance from BCBA.

C. Monthly Team Meetings:

a. BCBA, behavior technicians and parents will review program data and make necessary changes as a team.

To track progress and understanding of the skills we are reviewing, the team will be collecting data. Progress with your parent goals will be reviewed with you periodically and included in your child's progress reports that are completed every 6 months.

In order to promote learning and foster true independence in your child, parents will use the teaching opportunities offered to help generalize and maintain the skills learned through the ABA services. Through the Family Treatment Guidance, the ABA services will gradually fade and the skills learned by your child will transition to daily life and with the family.

I have read the above statements regarding active parental involvement in ABA therapy.

I understand that parent participation is an essential part of the ABA services my child is receiving.

I understand data will be collected and progress reviewed and included in progress reports submitted to insurance every 6 months.

I acknowledge that lack of proof of parent participation could put my child at risk of reduced hours in ABA services being approved by my insurance company.

Parent/Guardian Signature: Date:

Parent/Guardian Signature: Date:

Happyian, LLC Staff Signature: Date:

Parent/Caregiver COVID-19 Pandemic Precautions and Expectation

Updated February 3, 2023

Depending on the environmental situation and its severity Happyian, LLC will follow and implement all the State, CDC and WHO guidelines and recommendations. In such situations, please be accommodative and responsible by informing our staff about any possible risk factors. Happyian, LLC staff will inform the family about any illness or exposure and will be a reliable partner in ensuring a healthy environment for our client and families.

In case of any negligence the treatment services will be placed on hold till a decision is made. If our staff member is exposed due to failure of notice, Happyian, LLC will charge the client the entire session amount without billing the insurance. The staff member will leave immediately and the fee will be charged to the client and family. To ensure the safety of all who were potentially exposed, all necessary measures will be taken prior to resuming services. Staff will immediately discontinue home services. Criteria for staff re-entering home for sessions will be contingent on proof that the individual can resume daily life activities.

We assure you that Happyian, LLC management will work along all health care guidelines for the safety and well being of our clients, families and our staff members. We look forward for your mutual understanding and co-operation as needed.

I have read the above Happyian, LLC Pandemic precautions and expectations policy. I adhere to follow the guidelines if and as needed.

Parent / Caregiver Printed Name:

Client Name:

Parent /Caregiver Signature:

Date:

Happyian, LLC Staff Name:

Happyian, LLC Staff Signature:

Consent for Coordination of Care and Release of Information

Client Intake Form

Coordination of care with other educational and health care professionals helps ensure your child's progress as treatment goals are most likely to be achieved when there is a clear· understanding and open communication within the child's team of providers.

Child's First and Last Name: -

DOB: ·-

Primary Care Physician		
Name:	**Phone:**	**Fax:**
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.		

Diagnostic Practitioner		
Name:	**Phone:**	**Fax:**
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.		

Medical Specialist		
Name:	**Phone:**	**Fax:**
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.		

School / Daycare Facility		
School Name:	**Phone:**	**Fax:**
Teacher(s) Name:	**Email:**	
Social worker/Counselor:	**Email:**	
Speech Therapist:	**Email:**	
Occupational Therapist:	**Email:**	
Other:		
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.		

Outside Therapy Provider(s)		
Clinician Name:	**Email:**	
Facility Name:	**Phone:**	**Fax:**
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.		
Clinician Name:	**Email:**	
Facility Name:	**Phone:**	**Fax:**
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.		
Clinician Name:	**Email:**	
Facility Name:	**Phone:**	**Fax:**

I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider.

Previous Therapy Provider		
Clinician Name:	**Email:**	
Facility Name	**Phone:**	**Fax:**
I give consent for Happyian, LLC to coordinate care with the above provider. I do not give consent for Happyian, LLC to coordinate care with the above provider		

The above consent is valid for a period of one year and will expire on _____.

For any changes to be made or this consent to be revoked the parent/guardian must submit a written request to the Happyian, LLC staff.

Happyian, LLC

Address:

Parent /Guardian Printed Name:

Parent/Guardian Signature:

Date:

Happyian, LLC Staff Printed Name:

Happyian, LLC Staff Signature:

Date:

Phone: 773-553-0900 - Fax: 833-409-2227 - www.Happyian.com -
happyian@happyianaba.com